Dr. Tran Miller, DMD

199 SW Shelvin Hixon Drive, Suite A ● Bend, OR 97702

P: (541)330-5952 F: (541)330-5935

Initial Evaluation Consents

Name:_____DOB:_____

Authorization for the Initial Visit

I understand that my appointment is for an evaluation and consultation. The visit will consist of review of my medical history and any reports that are available and clinical examination followed by a consultation and discussion of the findings and the recommended course of treatment/action.

Signature: _____

Authorization to Submit Insurance Claim

I authorize Mark E Jensen LLC to submit claims on my behalf for payment of services rendered to the named insurance company. I understand that if the insurance company denies payment of the claim(s), or if payment is directly mailed to me, I become the responsible party for the payment of the services rendered. After 30 days, I accept full responsibility for any payments due.

Signature: _____

Authorization for Release of Health Information

I authorize Mark E Jensen LLC to release information relative to my medical history, diagnosis and treatment to the named insurance company or to any health care provider related to my treatment.

Signature: _____

I verify that all of the information provided is accurate and correct and that all medical/health conditions as well as all of the medications I have been taking is disclosed.

Signature: _____